HealthSCOPE BENEFITS

MAIL COMPLETED CLAIM FORM TO:
HealthSCOPE Benefits
P. O. Box 99006
Lubbock, TX 79490-9006

Medical Claim Form

Please refer to instructions on the back of this form. A properly completed form will expedite the processing of your claim.

I. COMPLETE FOR ALL MEDICAL CLAIMS

Employee Social Security Number	**Employee Name (Last, First, Middle)**	**Employee Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated

II. COMPLETE FOR DEPENDENT CLAIMS ONLY

Dependent Name (Last, First, Middle)		**Relationship to Employee**	
If claim is for dependent child over age 19 at the time the claim was incurred, was the dependent: **(if "B", see instruction number 5 on the reverse side of this form)**	☐ Disabled? ☐ A student and/or financially dependent on you?	☐ Yes ☐ No ☐ Yes ☐ No	
Name of Spouse / Dependent with other Coverage	**Social Security Number**	**Plan Number**	
Name and Address of Other Carrier	**Name and Address of Other Employer**		

III. COMPLETE FOR ACCIDENTS ONLY

How, when and where did the accident occur?		
Did the accident happen during the course of employment?	Yes ☐	No ☐
If so, has a Workmen's Compensation claim been filed?	Yes ☐	No ☐

IV. COMPLETE FOR ALL MEDICAL CLAIMS (Authorization)

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide HealthSCOPE Benefits, or an agent, attorney, consumer reporting agency or independent administrator acting on it s behalf, in formation concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs, or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide HealthSCOPE Benefits, Inc. with financial or employment-relation information.

I understand that HealthSCOPE Benefits will use such information for the purpose of evaluating my claim for benefits and that I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed for the duration of the claim. I agree that a photographic copy of this authorization shall be valid as the original.

It is a crime to complete this form with information that you know is false, or to omit any facts that you know are

Patient Signature (if over 18 years of age)	Date Signed (Mo/Day/Year)	I authorize payment of medical benefits to the provider whose bills are attached.
Employee Signature (if over 18 years of age)	Date Signed (Mo/Day/Year)	_____ Employee Signature

(OVER)

Medical Claim Form Instructions

1. **Use a separate claim form for each family member.** If the bill shows expenses for more than one family member, highlight the name of the patient for whom this claim is being submitted.

2. **Complete the applicable Sections of the claim form for each claim.**

3. **All bills must be itemized and include the patient's name, date of service, amount charged for service and diagnosis.** Expenses may be submitted by having your doctor complete an Attending Physician's Statement, which your doctor will provide. Do not submit photocopies, cash register receipts or cancelled checks. Make copies of all claims before they are submitted. Claim personnel cannot provide copies.

4. **If HealthSCOPE Benefits, Inc is not the primary carrier for this claim, submit an original Explanation of Benefits (EOB) from the primary payor and copies of the bills.** Claims cannot be processed without the other plan's EOB.

5. **If the claim is for a dependent age 19 or older who attends an educational institution on a full-time basis and is financially dependent on you for support, you may be required to provide proof of attendance (tuition receipt or letter from school) reflecting full-time student status during the period in which the dependent was treated.**

6. **Payments are made to you unless indicated on the claim form**. If you want benefits paid directly to a provider, sign your full name on the front of this form (bottom right hand side).

7. **Sign and date the front side of this form (bottom left hand side), indicating the information provided is correct and authorizing release of information necessary to process this claim.**

8. **Submit claims with this claim form to:**

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